

**HOME HEALTH AGENCY SURVEY
AND DEFICIENCIES REPORT**

1. Name of Facility:		11. Provider No.: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>	
2. Street Address:		12. Type of Survey: <div style="display: flex; justify-content: space-around;"><div style="text-align: center;"><input type="checkbox"/> Initial (G2) 1 = Standard 2 = Partial Extended 3 = Extended</div><div style="text-align: center;"><input type="checkbox"/> Resurvey (G3) 4 = 1 and 2 5 = 1 and 3 6 = 1, 2 and 3</div></div>	
3. City and/or County:	4. State:	13. Eligibility: (G7) <div style="text-align: center;"><input type="checkbox"/> 1 = Medicare 2 = Medicaid 3 = Both</div>	
5. Zip Code:	6. Telephone No. (G4)		
7. State/County Code: (G5)	8. State/Region Code: (G6)	14. Has there been a change of ownership since last survey? (G9) <div style="display: flex; justify-content: space-around;"><div style="text-align: center;"><input type="checkbox"/> Yes</div><div style="text-align: center;"><input type="checkbox"/> No</div></div>	
9. Name of Administrator:			
10. Discipline of Administrator: (G8) <div style="display: flex; justify-content: space-between; font-size: small;"><div>1 = RN/LPN 2 = Physician 3 = PT/OT 4 = Speech Path/Audiologist</div><div>5 = Medical/License Social Worker 6 = Pub Adm/MBA/ACCT 7 = Lawyer 8 = Proprietor</div><div>9 = Other</div></div>		15. A. Is this home health agency also a Medicare certified hospice? (G10) <div style="display: flex; justify-content: space-around;"><div style="text-align: center;"><input type="checkbox"/> Yes</div><div style="text-align: center;"><input type="checkbox"/> No</div></div> <div style="margin-top: 5px;">If yes, give the hospice Medicare provider number: (G11) <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div></div>	
15. B. Does this home health agency operate sub-units? (G12) <div style="margin-top: 5px;">If yes, how many: (G13) <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div></div>			
15. C. Is this home health agency a sub-unit? (G14) <div style="margin-top: 5px;">If yes, parent agency provider number: (G15) <div style="border: 1px solid black; width: 100px; height: 20px; display: inline-block;"></div></div>		15. D. Does this home health agency or sub-unit operate branch(es)? (G16) <div style="display: flex; justify-content: space-around;"><div style="text-align: center;"><input type="checkbox"/> Yes</div><div style="text-align: center;"><input type="checkbox"/> No</div></div> <div style="margin-top: 5px;">If yes, how many: (G17) <div style="border: 1px solid black; width: 40px; height: 20px; display: inline-block;"></div></div> <div style="margin-top: 5px;">If yes, give official name and mailing address of each branch (include street, state and zip code): <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div></div>	
16. Type of Agency: (G18) <div style="display: flex; align-items: flex-start;"><div style="border: 1px solid black; width: 40px; height: 20px; margin-right: 5px;"></div><div style="border: 1px solid black; width: 40px; height: 20px; margin-right: 5px;"></div><div style="font-size: small;">01 = VNA 02 = Combination Government Voluntary 03 = Official Health Agency 04 = Rehab based program* 05 = Hospital based program* 06 = Skilled Nursing Facility/Nursing Facility based program* 07 = Other</div></div> <div style="margin-top: 10px;">*If Medicare/Medicaid certified give the provider number: (G19) <div style="border: 1px solid black; width: 100px; height: 20px; display: inline-block;"></div></div>			
17. Type of Control: (G20) <div style="display: flex; align-items: flex-start;"><div style="border: 1px solid black; width: 40px; height: 20px; margin-right: 5px;"></div><div style="border: 1px solid black; width: 40px; height: 20px; margin-right: 5px;"></div><div style="font-size: small;">Voluntary Non-Profit 01 = Religious Affiliation 02 = Private 03 = Other For Profit 04 = Proprietary Government 05 = State/County 06 = Combination Govt. and Voluntary 07 = Local Government</div></div>			
		17. Type of Control: (G20) <div style="display: flex; align-items: flex-start;"><div style="border: 1px solid black; width: 40px; height: 20px; margin-right: 5px;"></div><div style="border: 1px solid black; width: 40px; height: 20px; margin-right: 5px;"></div><div style="font-size: small;">Voluntary Non-Profit 01 = Religious Affiliation 02 = Private 03 = Other For Profit 04 = Proprietary Government 05 = State/County 06 = Combination Govt. and Voluntary 07 = Local Government</div></div>	

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(continued)

18. Services Offered: (G21)

1 = Provided by Agency Staff

2 = Under Arrangement

3 = Combination

- | | |
|--------------------------|--------------------------------------|
| <input type="checkbox"/> | 01 = Nursing Care |
| <input type="checkbox"/> | 02 = Physical Therapy |
| <input type="checkbox"/> | 03 = Occupational Therapy |
| <input type="checkbox"/> | 04 = Speech Therapy |
| <input type="checkbox"/> | 05 = Medical Social Worker |
| <input type="checkbox"/> | 06 = Home Health Aide |
| <input type="checkbox"/> | 07 = Intern/Resident |
| <input type="checkbox"/> | 08 = Nutritional Guidance |
| <input type="checkbox"/> | 09 = Pharmaceutical Services |
| <input type="checkbox"/> | 10 = Appliance and Equipment Service |
| <input type="checkbox"/> | 11 = Vocational Guidance |
| <input type="checkbox"/> | 12 = Laboratory Services |
| <input type="checkbox"/> | 13 = Other |

19. Staffing (List full-time equivalent):

Registered Nurse (G22)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
Licensed Practical Nurse (G23)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapist (G24)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapist (G25)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
Speech Pathologist/Audiologist (G26)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
Social Worker (G27)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
Home Health Aide (G28)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
Pharmacist (G29)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
Dietitian (G30)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>
All Others (G31)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	•	<input type="checkbox"/>	<input type="checkbox"/>

20. Home Health Agency provides directly: (G32)

- | | |
|--------------------------|--|
| <input type="checkbox"/> | 1 = Home Health aide training program |
| <input type="checkbox"/> | 2 = Home Health aide competency evaluation program |
| <input type="checkbox"/> | 3 = Both |
| <input type="checkbox"/> | 4 = Neither |

21. Number records reviewed with home visits (G33)

Number records reviewed, no home visits (G34)

Number of home visits with no records review (G35)

Total records reviewed (G36)

Total home visits (G37)

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

22. Patient census since last standard survey:

Admissions:

(G38) _____ Unduplicated admissions

(G39) _____ Readmissions

Discharges

(G40) _____ Hospital discharges

(G41) _____ Nursing home discharges

(G42) _____ Goals met discharges

(G43) _____ Death discharges

(G44) _____ Total discharges

23. Surveyor summary: Based on the reviews of the patients from this home health agency including all information surveyed in the standard survey and using the Functional Assessment Instrument (FAI), this home health agency: (G45)

- ☐ 1. Provides care that promotes a high potential for reaching the highest attainable levels of functioning for its patients. There is no evidence of need for a partial extended or extended survey.
- ☐ 2. Provides care that promotes a moderate potential for reaching the highest level of functioning for some but not all of its patients. There are standard level deficiencies and need for a partial extended survey. If no conditions are out of compliance, a Plan of Correction will be requested for the standard level deficiencies.
- ☐ 3. Provides substandard care. There are condition level deficiencies in one or more Conditions of Participation. There is an immediate need for an extended survey.

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Page _____ of _____

1. NAME OF FACILITY:

4. DATE:

2. DEFICIENCIES

3. Standard _____ Extended _____ Partial Extended _____

Data Tag No.

COP/Stnd No.

COMMENTS

2. DEFICIENCIES		3. Standard _____ Extended _____ Partial Extended _____
Data Tag No.	COP/Stnd No.	COMMENTS

HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT INSTRUCTIONS

Record deficiencies identified on a Standard Survey, Partial Extended Survey, and/or Extended Survey on different pages, check the type of survey under item 3 and enter the date of the survey in item 4.

- A. In the first column, identify the data tag number.
- B. In the second column, write the regulatory citation. If it is a Condition of Participation, enter "CoP" below the regulatory citation.
- C. In column three, describe the findings and evidence under "Comments."
- D. Draw horizontal lines to separate identified tag numbers.
- E. If more space is needed, photocopy the "Deficiencies & Comments" page and continue the recording (front and back).
- F. Each surveyor must sign the certifying statement on the last page for each type survey(s) conducted (i.e., Standard Survey, Partial Extended Survey, and/or Extended Survey). If more space is needed to list deficiencies identified during a Partial Extended Survey, photocopy page.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0355. The time required to complete this information collection is estimated to average 45 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

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Page ____ of ____

A. STANDARD SURVEY

I certify that I have reviewed each HHA Condition of Participation and related Standard(s) included in the Standard survey and except as indicated on this form, the facility was found to be in compliance with the standards and/or the Conditions of Participation.

Signature: _____	Title: _____	Date: _____
Signature: _____	Title: _____	Date: _____
Signature: _____	Title: _____	Date: _____

B. PARTIAL EXTENDED SURVEY

I certify that I have reviewed each HHA Condition of Participation and related Standard(s) listed below, and except as indicated on this form, the facility was found to be in compliance with the standards and/or the Conditions of Participation.

Signature: _____	Title: _____	Date: _____
Signature: _____	Title: _____	Date: _____
Signature: _____	Title: _____	Date: _____

C. EXTENDED SURVEY

I certify that I have reviewed all of the HHA Conditions of Participation and related Standard(s) not reviewed during the Standard Survey and/or Partial Extended Survey and except as indicated on this form, the facility was found in compliance with the standards and/or Conditions of Participation.

Signature: _____	Title: _____	Date: _____
Signature: _____	Title: _____	Date: _____
Signature: _____	Title: _____	Date: _____